

Facility Name & ID Number Chicago Ridge Nursing Center

0045815 Report Period Beginning: 01/01/2006 Ending: 01/01/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 234

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>231</u>	Skilled (SNF)	<u>231</u>	<u>84,315</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>231</u>	TOTALS	<u>231</u>	<u>84,315</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>71,175</u>	<u>1,435</u>	<u>5,174</u>	<u>77,784</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>71,175</u>	<u>1,435</u>	<u>5,174</u>	<u>77,784</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.25%

D. How many bed-hold days during this year were paid by the Department? 2,387 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 11/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/01/2001 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 38 and days of care provided 3,925

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2006 Ending: 01/01/2006

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	229,973	29,971	9,547	269,491		269,491	16,659	286,150		1
2	Food Purchase		270,853		270,853		270,853	(5,405)	265,448		2
3	Housekeeping	177,165	23,093		200,258		200,258		200,258		3
4	Laundry	84,056	14,103		98,159		98,159		98,159		4
5	Heat and Other Utilities			193,871	193,871		193,871	3,266	197,137		5
6	Maintenance	26,549	42,791		69,340		69,340	113,007	182,347		6
7	Other (specify):* See Attached Sch			16,746	16,746		16,746		16,746		7
8	TOTAL General Services	517,743	380,811	220,164	1,118,718		1,118,718	127,527	1,246,245		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,043,013	71,383	2,353	2,116,749		2,116,749		2,116,749		10
10a	Therapy	1,122		23,350	24,472		24,472		24,472		10a
11	Activities	77,221	1,276		78,497		78,497		78,497		11
12	Social Services	114,321	30,800	1,353	146,474		146,474		146,474		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,235,677	103,459	27,056	2,366,192		2,366,192		2,366,192		16
	C. General Administration										
17	Administrative	24,231		530,541	554,772		554,772	(275,004)	279,768		17
18	Directors Fees										18
19	Professional Services			73,118	73,118		73,118		73,118		19
20	Dues, Fees, Subscriptions & Promotions			41,989	41,989		41,989	(14,671)	27,318		20
21	Clerical & General Office Expenses	52,526		35,449	87,975		87,975	98,950	186,925		21
22	Employee Benefits & Payroll Taxes			364,685	364,685		364,685	36,906	401,591		22
23	Inservice Training & Education										23
24	Travel and Seminar			870	870		870		870		24
25	Other Admin. Staff Transportation							1,198	1,198		25
26	Insurance-Prop.Liab.Malpractice			240,858	240,858		240,858	725	241,583		26
27	Other (specify):* Medical Records	73,258			73,258		73,258		73,258		27
28	TOTAL General Administration	150,015		1,287,510	1,437,525		1,437,525	(151,896)	1,285,629		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,903,435	484,270	1,534,730	4,922,435		4,922,435	(24,369)	4,898,066		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Chicago Ridge Nursing Center

#0045815

Report Period Beginning:

01/01/2006

Ending:

01/01/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			21,431	21,431		21,431	(6,454)	14,977			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,430	8,430		8,430	(8,430)				32
33	Real Estate Taxes					384,553	384,553		384,553			33
34	Rent-Facility & Grounds			1,538,041	1,538,041	(384,553)	1,153,488		1,153,488			34
35	Rent-Equipment & Vehicles			5,965	5,965		5,965	676	6,641			35
36	Other (specify):*											36
37	TOTAL Ownership			1,573,867	1,573,867		1,573,867	(14,208)	1,559,659			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		160,806	197,465	358,271		358,271		358,271			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,473	126,473		126,473		126,473			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		160,806	323,938	484,744		484,744		484,744			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,903,435	645,076	3,432,535	6,981,046		6,981,046	(38,577)	6,942,469			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **Chicago Ridge Nursing Center**

0045815

Report Period Beginning:

01/01/2006

Ending:

01/01/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,454)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,405)	2		13
14	Non-Care Related Interest	(8,430)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,868)	21		18
19	Entertainment				19
20	Contributions	(680)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(12,033)	20		28
29	Other-Attach Schedule <u>See Attached Schedule</u>	(1,707)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,577)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (38,577)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Chicago Ridge Nursing Center

ID# 0045815

Report Period Beginning: 01/01/2006

Ending: 01/01/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Deductible Dues	\$ (3,829)	20	1
2	Franchise Tax from Management Company	(27)	21	2
3	Auto Expense paid by the related entity and			3
4	properly allocated to this facility	1,321	25	4
5	Non Allowable Personal Auto Use	(222)	25	5
6	Background Checks paid by the related entity on			6
7	behalf of this facility	1,050	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,707)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center# 0045815

Report Period Beginning:

01/01/2006

Ending:

01/01/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	16,659	0	0	0	0	0	0	0	0	16,659	1
2	Food Purchase	(5,405)	0	0	0	0	0	0	0	0	0	0	(5,405)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,266	0	0	0	0	0	0	0	0	0	3,266	5
6	Maintenance	0	1,494	111,513	0	0	0	0	0	0	0	0	113,007	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,405)	4,760	128,172	0	127,527	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(275,004)	0	0	0	0	0	0	0	0	(275,004)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(14,812)	141	0	0	0	0	0	0	0	0	0	(14,671)	20
21	Clerical & General Office Expenses	(4,575)	1,577	101,948	0	0	0	0	0	0	0	0	98,950	21
22	Employee Benefits & Payroll Taxes	0	36,906	0	0	0	0	0	0	0	0	0	36,906	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	1,099	99	0	0	0	0	0	0	0	0	0	1,198	25
26	Insurance-Prop.Liab.Malpractice	0	725	0	0	0	0	0	0	0	0	0	725	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(18,288)	39,448	(173,056)	0	(151,896)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,693)	44,208	(44,884)	0	(24,369)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chicago Ridge Nursing Center# 0045815

Report Period Beginning:

01/01/2006 Ending:

01/01/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(6,454)	0	0	0	0	0	0	0	0	0	0	(6,454)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,430)	0	0	0	0	0	0	0	0	0	0	(8,430)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	676	0	0	0	0	0	0	0	0	0	676	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(14,884)	676	0	0	0	0	0	0	0	0	0	(14,208)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(38,577)	44,884	(44,884)	0	(38,577)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00	Balmoral Home, Inc.	Chicago, IL	Nivram Mngt, Inc.	Lincolnwood, IL	Management
Joseph Mermelstein Trust	25.00	Central Home, Inc.	Chicago, IL			
Barry Taerbaum	25.00	RREM Inc. d/b/a Winston Manor Nursing Home	Chicago, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	21	Bank Charges	Nivram Management, Inc.	50.00%	\$ 21	\$ 21	1	
2	V	21	Office Expense	Nivram Management, Inc.	50.00%	840	840	2	
3	V	20	Dues & Subscriptions	Nivram Management, Inc.	50.00%	141	141	3	
4	V	21	Franchise Tax	Nivram Management, Inc.	50.00%	27	27	4	
5	V	22	Payroll Taxes	Nivram Management, Inc.	50.00%	34,314	34,314	5	
6	V	5	Utilities	Nivram Management, Inc.	50.00%	3,266	3,266	6	
7	V	26	Insurance	Nivram Management, Inc.	50.00%	725	725	7	
8	V	6	Repairs & Maintenance	Nivram Management, Inc.	50.00%	1,228	1,228	8	
9	V	22	Health Insurance	Nivram Management, Inc.	50.00%	2,592	2,592	9	
10	V	6	Scavenger	Nivram Management, Inc.	50.00%	266	266	10	
11	V	35	Rental Equipment	Nivram Management, Inc.	50.00%	676	676	11	
12	V	25	Auto Expense	Nivram Management, Inc.	50.00%	99	99	12	
13	V	21	Postage	Nivram Management, Inc.	50.00%	689	689	13	
14	Total		\$			\$ 44,884	\$ *	44,884	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21 Data Processing	\$	Nivram Management, Inc.	50.00%	\$ 430	\$	430	15
16	V	21 Telephone		Nivram Management, Inc.	50.00%	1,342		1,342	16
17	V	6 Plant Salary		Nivram Management, Inc.	50.00%	31,898		31,898	17
18	V	17 Assistant Administrator Salary		Nivram Management, Inc.	50.00%	47,847		47,847	18
19	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	19,634		19,634	19
20	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	16,659		16,659	20
21	V	17 Administrative Salary		Nivram Management, Inc.	50.00%	71,536		71,536	21
22	V	17 Administrator Salary		Nivram Management, Inc.	50.00%	136,154		136,154	22
23	V	21 Clerical Salaries		Nivram Management, Inc.	50.00%	80,542		80,542	23
24	V	6 Maintenance Salary		Nivram Management, Inc.	50.00%	79,615		79,615	24
25	V	17 Management Fees	530,541	Nivram Management, Inc.	50.00%			(530,541)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 530,541			\$ 485,657	\$ *	(44,884)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2006 Ending: 01/01/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrative	Administrative	0.00	228,717	7	16.83	Salary	\$ 46,283	17-1	1
2	Louise Mermelstein	Food Service Supp.	Food Service Supp	0.00	73,341	7	18.51	Salary	16,659	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	88,102	5	26.58	Salary	31,898	1-7	3
4	Doreen Marmelstein	Office Manager	Administrative	0.00	83,926	8	18.96	Salary	19,634	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	132,153	7	26.58	Salary	47,847	17-7	6
7	Joseph Mermelstein	Owner	Administrative	25.00	69,747	3	26.58	Salary	25,253	17-7	7
8	Barry Taerbaum	Owner	Administrative	25.00	150,000	4	11.00	Salary	35,000	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 222,574		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Chicago Ridge Nursing Center# 0045815

Report Period Beginning:

01/01/2006Ending: 1/01/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Nivram Management, Inc.

Street Address

6500 N. Hamlin Ave.

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 679-7484

Fax Number

(847) 679-7494

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	869	4	\$ 80	\$ 231	\$ 21	1
2	21	Office Expense	Resident Beds	869	4	3,160	231	840	2
3	20	Dues & Subscriptions	Resident Beds	869	4	530	231	141	3
4	21	Franchise Tax	Resident Beds	869	4	100	231	27	4
5	22	Payroll Taxes	Resident Beds	869	4	129,086	231	34,314	5
6	5	Utilities	Resident Beds	869	4	12,288	231	3,266	6
7	26	Insurance	Resident Beds	869	4	2,728	231	725	7
8	6	Repairs & Maintenance	Resident Beds	869	4	4,620	231	1,228	8
9	22	Health Insurance	Resident Beds	869	4	9,750	231	2,592	9
10	6	Scavenger	Resident Beds	869	4	1,000	231	266	10
11	35	Rental Equipment	Resident Beds	869	4	2,544	231	676	11
12	25	Auto Expense	Resident Beds	869	4	374	231	99	12
13	21	Postage	Resident Beds	869	4	2,591	231	689	13
14	21	Data Processing	Resident Beds	869	4	1,616	231	430	14
15	21	Telephone	Resident Beds	869	4	5,049	231	1,342	15
16	6	Plant Salary	Direct Cost	1	1	31,898	31,898	1	31,898
17	17	Assistant Administrator Salary	Direct Cost	1	1	47,847	47,847	1	47,847
18	21	Office Manager Salary	Direct Cost	1	1	19,634	19,634	1	19,634
19	1	Food Service Supervisor Salary	Direct Cost	1	1	16,659	16,659	1	16,659
20	17	Administrative Salaries	Direct Cost	1	1	71,536	71,536	1	71,536
21	17	Administrator Salaries	Direct Cost	1	1	136,154	136,154	1	136,154
22	21	Clerical Salaries	Direct Cost	1	1	80,542	80,542	1	80,542
23	6	Maintenance Salary	Direct Cost	1	1	79,615	79,615	1	79,615
24									24
25	TOTALS					\$ 659,401	\$ 483,885	\$ 530,541	25

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2006

Ending:

01/01/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Parkway Bank & Trust		X	Line of Credit		7/18/05		75,000	1/18/06	5.2500	8,430									
7	Offset Against Int Inc										(8,430)									
8																				
9	TOTAL Facility Related						\$	75,000			\$									
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related						\$				\$									
15	TOTALS (line 9+line14)						\$	75,000			\$									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	(12,771)	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	343,030	2
3. Under or (over) accrual (line 2 minus line 1).		\$	355,801	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	28,752	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	384,553	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	358,079	8
	2002	374,839	9
	2003	386,154	10
	2004	399,465	11
	2005	437,990	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chicago Ridge Nursing Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045815

CONTACT PERSON REGARDING THIS REPORT Sanford B Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>24-18-101-025-0000</u>	<u>Nursing Home</u>	\$ <u>321,067.32</u>	\$ <u>321,067.32</u>
2. <u>24-18-101-039-0000</u>	<u>Nursing Home</u>	\$ <u>116,922.82</u>	\$ <u>116,922.82</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>437,990.14</u>	\$ <u>437,990.14</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2006 Ending:

01/01/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 87,480 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3 + Basement

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>73,980</u>		\$	1
2					2
3	TOTALS	73,980		\$	3

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2006 Ending: 01/01/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	231			\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sign		2001	1,419	36	39	36		186	9
10	Carpet		2002	2,240	58	39	58		259	10
11	Alarm		2002	22,000	564	39	564		2,538	11
12	Washer & Dryer		2002	29,304	751	39	751		3,382	12
13	Phone System		2002	10,667	273	39	273		1,231	13
14	A/C System		2002	11,200	287	39	287		1,293	14
15	Electrical Improvement		2002	3,000	77	39	77		346	15
16	Light Fixtures		2002	10,192	261	39	261		1,176	16
17	RC Alarm		2003	4,500	116	39	116		433	17
18	Water Heater		2003	16,500	2,257	39	423	(1,834)	1,692	18
19	Boiler		2004	21,500	552	39	552		1,654	19
20	Paving Improvements		2005	21,800	1,453	39	559	(894)	1,118	20
21	Bathroom Improvements		2005	634	16	39	16		32	21
22	Fire Smoke Dampers		2005	3,475	89	39	89		178	22
23	Boiler		2005	11,960	5,143	39	307	(4,836)	614	23
24	Locks		2006	4,374	9	39	112	103	112	24
25	Fire Alarm System		2006	98,711	211	39	2,531	2,320	2,531	25
26	AC Chiller Unit		2006	81,000	1,731	39	1,038	(693)	1,038	26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	354,476	\$	13,884	\$	8,050	\$	(5,834)	\$	19,813	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 58,698	\$ 7,157	\$ 5,870	\$ (1,287)	10	\$ 25,735	71
72	Current Year Purchases	3,415	390	342	(48)	10	342	72
73	Fully Depreciated Assets							73
74	Management Company			715	715	10	2,422	74
75	TOTALS	\$ 62,113	\$ 7,547	\$ 6,927	\$ (620)		\$ 28,499	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 416,589	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,431	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,977	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,454)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 48,312	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		231	11/01/01	\$ 1,538,041	30	30	3
4	Additions							4
5								5
6								6
7	TOTAL		231		\$ 1,538,041			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ 5,965 Description: Copier - \$2,965; A/C Units - \$3,000

YES NO

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 11/01/2001

Ending 10/31/2031

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2007 \$ 1,657,915

13. 12/31/2008 \$ 1,700,072

14. 12/31/2009 \$ 1,742,230

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			197,465			197,465	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				142,880		142,880	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Attached Sch</u>	39-2					17,926		17,926	13
14	TOTAL			\$		\$ 197,465	\$ 160,806		\$ 358,271	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning: 01/01/2006

Ending:

01/01/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/01/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 32,791	\$ 62,874	1
2	Cash-Patient Deposits	24,664	24,664	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,523,184	1,523,184	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	151,781	151,781	6
7	Other Prepaid Expenses	126,039	126,039	7
8	Accounts Receivable (owners or related parties)	428	71,280	8
9	Other(specify): <u>Loan Receivable - Employee</u>	6,444	6,444	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,865,331	\$ 1,966,266	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	296,715	296,715	15
16	Equipment, at Historical Cost	119,876	208,783	16
17	Accumulated Depreciation (book methods)	(83,190)	(172,097)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	32,500	32,500	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 365,901	\$ 365,901	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,231,232	\$ 2,332,167	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 307,210	\$ 307,210	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,228	2,228	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,194	108,194	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Line of Credit</u>	75,000	75,000	36
37	<u>See Attached Schedule</u>	1,322,077	2,904,168	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,814,709	\$ 3,396,800	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,814,709	\$ 3,396,800	46
47	TOTAL EQUITY (page 18, line 24)	\$ 416,523	\$ (1,064,633)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,231,232	\$ 2,332,167	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 54,228	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 54,227	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,332,296	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,970,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 362,296	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 416,523	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,070,991	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,070,991	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	72,742	6
7	Oxygen	69,024	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 141,766	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,853	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 29,853	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	65,396	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 65,396	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	3,900	28
28a	<u>Discount Earned</u>	1,436	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,336	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,313,342	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	5,025,388	31
32	Health Care	1,597,387	32
33	General Administration	358,271	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,981,046	40
41	Income before Income Taxes (line 30 minus line 40)**	2,332,296	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,332,296	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2006

Ending:

01/01/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,563	2,731	\$ 84,974	\$ 31.11	1
2	Assistant Director of Nursing	2,174	2,206	50,504	22.89	2
3	Registered Nurses	14,319	14,319	399,402	27.89	3
4	Licensed Practical Nurses	34,037	34,395	738,850	21.48	4
5	CNAs & Orderlies	78,045	82,151	769,283	9.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	132	132	1,122	8.50	8
9	Activity Director	2,080	2,160	25,694	11.90	9
10	Activity Assistants	6,117	6,438	51,527	8.00	10
11	Social Service Workers	7,870	8,118	114,321	14.08	11
12	Dietician					12
13	Food Service Supervisor	2,166	2,199	25,322	11.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,368	24,157	204,651	8.47	15
16	Dishwashers					16
17	Maintenance Workers	2,286	2,414	26,549	11.00	17
18	Housekeepers	22,911	23,935	177,165	7.40	18
19	Laundry	9,967	10,639	84,056	7.90	19
20	Administrator					20
21	Assistant Administrator	1,734	1,734	24,231	13.97	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,522	5,740	52,526	9.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,656	5,672	73,258	12.92	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	218,947	229,140	\$ 2,903,435 *	\$ 12.67	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 9,547	1-3	35
36	Medical Director	O	2,353	10-3	36
37	Medical Records Consultant	N			37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L	638	10a-3	40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	1,353	12-3	45
46	Other(specify) <u>MDS</u>	S	22,712	10a-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,603		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sharon Washington	Assist. Admn	0.00	\$ 24,231	Workers' Compensation Insurance	\$ 47,820	IDPH License Fee	\$ 4,490	
				Unemployment Compensation Insurance	71,100	Advertising: Employee Recruitment	5,120	
				FICA Taxes	220,672	Health Care Worker Background Check	1,050	
				Employee Health Insurance	25,093	(Indicate # of checks performed 105)		
				Employee Meals		Patient Background Checks	3,380	
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Page Advertising	12,033	
				Allocation from Management Company	36,906	See Attached Schedule	13,137	
						Allocation from Management Company	141	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 24,231					
B. Administrative - Other								
Description			Amount					
Management Fees			\$ 530,541			Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	(12,033)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 530,541	TOTAL (agree to Schedule V, line 22, col.8)	\$ 401,591	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 27,318	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Attached Schedule			\$ 73,118				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	870
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 73,118	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 870

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning: 01/01/2006

Ending: 01/01/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council Long Term Care \$14,819
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 126,473
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? N/A
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees